Partridge (E. L.)

REMARKS

ON THE

HISTORY AND TREATMENT OF TWO CASES

OF

FACE-PRESENTATION.

BY

EDWARD L. PARTRIDGE, M. D.

NEW YORK.

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REMARKS ON HISTORY AND TREATMENT OF TWO CASES OF FACE-PRESENTATION.

In the following records of two cases of face-presentation, no points of extraordinary interest are to be found; yet, in the details of these histories, several phenomena may engage attention: and the consideration of some expedients adopted in the treatment, together with their results, may be of service as testimony in favor of a method sometimes overlooked.

Case I.—Caroline R., aged twenty-seven years, single, was admitted to the lying-in department of the New York Infant Asylum, in January, 1876. She gave a history of good health previous to and during pregnancy. This pregnancy, which was her first, dated, as she supposed, from April 20th, at which time, according to her statement, her last menstruation occurred.

Upon admission her condition was excellent, the only symptom which occasioned annoyance being very great œdema of the lower extremities. Frequent examinations of her urine failed always to show the presence of albumen.

The anasarca which, as we have said, was extreme, continued to be present until four days previous to labor, when one morning she found that *none* existed, nor did it return *at all* subsequently.

At 5 A. M., February 24th, the membranes ruptured, no pain from uterine contractions having been experienced. At

noon I visited the patient, and, on vaginal examination, found an os which would not admit the finger. Through the vaginal uterine wall the cephalic extremity of the child could be distinguished. Thus far uterine contractions had been slight and infrequent. At 6 P. M., two fingers could be introduced into the os, and the presentation and position were determined to be face—the chin posterior and to the mother's right side, brow anterior and to the left.

At 8.30 P. M., Dr. Nicoll was present with me, and vaginal exploration revealed the os nearly dilated; presentation and position as before. Labor-pains were short, occurring at long intervals, and gave the patient no annoyance.

Chloroform was administered; my right hand passed into the vagina, and by conjoined manipulation the child's head was flexed on its body, and a left occipito-anterior position thereby established. The manipulation required the introduction of the fingers only into the uterus. The palms were passed over the occiput, and, by slight downward traction, the change in the presentation was easily effected. The left hand assisted in the manœuvre by external, upward pressure, lifting, to some extent, the head out of the pelvis.

During the next three hours there was no improvement in the pains, the patient obtaining considerable rest and sleep. No advance was made, the head not even engaging in the pelvic brim. During this time the presentation and position showed no disposition to alter. Between the hours of one and six, A. M., the patient was not under observation. As she could obtain rest and sleep, I had retired to bed, and, as the pains did not increase in severity, I was not summoned until the latter hour.

At this time a *face* presentation existed, with the position originally described. The uterine contractions had not improved.

At 8 A. M., Drs. Burrall and Nicoll being present, chloroform was administered, and the operation of inducing flexion of the child's head was again successfully performed. The forceps was immediately applied, and the head, in the left occipito-anterior position, brought well down in the pelvis. The instrument was then removed, and, as good uterine

action occurred, the labor terminated naturally in about twenty minutes. Convalescence was normal in every respect. The child, which weighed eight pounds and a quarter, had temporary facial paralysis on one side, one blade of the forceps having made pressure in front of the ear.

Case II.—Sabrina S., aged fifteen years, single, was confined at the Infant Asylum, on September 12, 1876. The last menstruation of this patient occurred December 2d to 8th, the pregnancy being her first. During the last two months of utero-gestation she had several attacks of intermittent fever. Labor-pains commenced on the evening of September 10th, immediately after a severe chill which was followed by fever and sweating. On the 12th inst. she had another paroxysm of intermittent fever. The first stage of labor was much prolonged, without any apparent cause other than the malarial manifestations. When the os had reached the size of a quarter of a dollar, the presentation and position were found to be face, with the brow anterior and to the mother's left side, the chin being situated to the right, posteriorly.

At 5.30 p. m., of the 12th inst., in the presence of Drs. Burrall and Nicoll, the patient having been anæsthetized, I succeeded in converting, with my hand, the face-presentation into one of the first position of the vertex. The manipulation was the same as that adopted in the case just recorded. The membranes ruptured when the hand was passed into the vagina. The case was now normal with respect to the presentation and position. Excellent labor-pains followed, and the head descended to the pelvic outlet. At this time the mother was at the height of her fever, her pulse being from 130 to 140. The fœtal heart varied between 170 and 180 beats in the minute. The escape of the head from the bony pelvis was opposed by an abrupt projection forward of the coccyx at the sacro-coccygeal articulation. No progress was made for some time, during which—the patient being anæsthetized—attempts were made to overcome the deformity by the use of all the strength that could be brought to bear with the fingers. The forceps was finally applied, and three-quarters of an hour was occupied in delivery by this instrument. The child was still-born and weighed eight pounds. Exami-

nations made immediately after labor, and again three weeks later, revealed the fact that the deformity was not relieved by the pressure of the child's head during its extraction. No history could be obtained from the patient relative to any injury sustained in that region at any time previous to, or after, the occurrence of pregnancy. The free use of bisulphate of quinine prevented any recurrence of the malarial manifestations, and puerperal convalescence did not present any but normal symptoms.

In a review of these histories, we find in the first case a few facts apparently relative to the *time* at which the presentation of the face originally occurred, and to the *factors* influencing the presentation. Four days previous to the labor of the patient first mentioned, there was complete and permanent disappearance of an œdema of the lower extremities which previously was extreme. I think that the relief of this symptom was effected at this time by a transformation of a vertex presentation into one of the face. It is probable that the irregularities of the facial contour permitted free circulation through the veins conveying blood from the lower extremities, these veins having been previously obstructed by the pressure of the firm, even, rounded surface of the cranium. Authorities generally believe that a face-presentation occurs late in pregnancy, or during the changes immediately preceding, or occurring after, the commencement of uterine contractions. Judging from the facts in this case, it would appear reasonable to suppose that the change was effected four days previous to labor.

In the history of the second case, we find nothing to indicate the *time* of the change in presentation from vertex to face.

Regarding the mechanism by which a vertex presentation is converted into one of the face, we do not find any very great disparity in the views of different authors. According to the prevailing opinion the elements which, in the majority of cases, favor extension of the head and descent of the face, are uterine obliquity, a dolicho-cephalous form of the cranium, and a hitching of the occiput upon the brim of the pelvis. In the cases under consideration, the peculiar form of the child's

head was present. The occiput projected somewhat more than is usual, and consequently the posterior arm of the cranial lever was lengthened to some extent. In both cases there was slight *right* lateral obliquity. The occiputs of both children were, however, directed toward the mother's *left* side, and we must, therefore, eliminate lateral obliquity from the causes of the changes in these cases; because, in order to influence the presentation, the inclination of the uterus should have been toward the mother's *left* side. In the first case, it would appear as if the muscles governing the movements of the child's head acquired an unnatural action —during the time that the head had first been extended— which aided in the production and maintenance of the unnatural position of the child's head, because we found a reappearance of the face-presentation after it had been altered to one of the vertex. It will be observed from the history that, previous to the recurrence of the face-presentation, there had been no appreciable descent of the head, and consequently very little, if any, hitching of the occiput upon surrounding structures.

Another point illustrated in the second case was the influence of the malarial manifestations upon the duration of labor, and, more particularly, upon the length of the first stage. This influence I have observed as the only apparent cause of prolonged labors of other patients, in whom malarial poisoning existed.

3. We find, in the second case, a rapidity of the child's pulse proportionate to the frequency of that of the mother. When the mother's pulse was 140 in the minute, the fœtal heart ranged between 170 and 180. The same observation has been made in other cases in hospital and private practice.

4. We may call attention to the condition of the coccyx, present in our second patient — quite unusual when we consider her youth. No inconsiderable force was brought to bear upon the unnatural conformation without removing the deformity. From the absence of traumatism, we must infer that the condition was the result of disease—ossification at the sacro-coccygeal articulation being highly improbable at the age of fifteen years.

Finally, we come to a brief consideration of the treatment resorted to in these cases, chiefly regarding its feasibility and propriety. Judging from the success attending the adoption of the expedient on these three occasions, and reasoning *a priori*, it would appear as if no great difficulty would be encountered in efforts to induce flexion of an extended fœtal head, in many cases, where we find certain conditions favoring the procedure. The conditions of the maternal and fœtal parts *especially* favorable to the operation we would enumerate as follows: An os nearly or quite dilated; a face not engaged in, or, at least, capable of being readily lifted from, the pelvic brim; an unruptured bag of waters. In the majority of labors a stage is reached when there are present these conditions. A capacious vagina is certainly desirable, but in both of our cases we dealt with primiparæ, and, in the case in which we were successful in two attempts, there was absence of the liquor amnii. The use of chloroform for the purpose of relaxing the structures of the parturient canal, and of quieting the movements of the patient—and in order to obviate pain attending the introduction of the hand into the vagina—is of primary importance. The manipulation requires the presence of the fingers only, in the uterus, and does not involve any laceration of the cervix. If the membranes are unruptured until the hand is in the vagina, it would appear preferable then to rupture them, thus guarding against any over-distention of the uterus; and the presence of the wrist at the vaginal outlet would prevent the escape of much amniotic fluid. Passing the palms of the fingers over the occipital bone, and pressing them firmly against it, traction downward should be made. In our endeavors, not more than a few moments elapsed before we felt the head commence its flexion, and then complete flexion immediately followed. The other hand was found to be of great service, aiding by external manipulation. Having succeeded in effecting the alteration in presentation, it would be wise to watch the case closely, until the head becomes well engaged in the pelvis, in order to perceive any tendency to a return to the original presentation; and if the tendency appeared and uterine contractions

were inefficient, the forceps might very properly be employed, *simply* for the purpose of engaging the head.

It would seem as if the cases we have recorded presented the usual features of face-cases. Both women were at full time, and the children of more than the average size.

The lack of success attending the operation recommended by Baudelocque, which resembles this method of treatment in some respects, has, I think, led to some indifference on the part of many authorities toward all treatment of a similar nature. Then, too, the great danger of bringing about brow-presentation, when efforts to induce flexion are made after the head has descended into the pelvis, has had its influence tending against all measures in any way like it. Baudelocque advised an attempt to alter a presentation of the face to that of the vertex as soon as two fingers could be introduced into the os. Such an attempt must be attended with great difficulty, and by much unnecessary, and perhaps dangerous, stretching and laceration of the cervix. Moreover, we would be somewhat prone to meet with a return of the face-presentation—if a change had been accomplished—because the factors originally causing the presentation of the face would still be present in full force. If flexion were secured by his operation, some time would elapse before the completion of the first stage of labor and the engagement of the head in the pelvis. During this time, if the dolicho-cephalous form of cranium existed in the child, and there was uterine obliquity, a return to the face-presentation would be quite possible.

The question which remains to be asked is, which is preferable, leaving to Nature a labor in which we have face-presentation, or employing a method of treatment such as that adopted in the cases recorded here?

Playfair expresses the views of most obstetricians regarding the prognosis in face-cases, when he says: "As regards the mother, in the great majority of cases the prognosis is favorable, although the labor is apt to be prolonged, and she is, therefore, more exposed to the risks attending tedious delivery. As regards the child, the prognosis is much more unfavorable than in vertex-presentations." Statistics, as far as they have been obtained, demonstrate that, in cases where the

face descends with the chin posterior, no rotation taking place, death of an average-sized child almost invariably occurs. Fortunately, in most cases, Nature effects a rotation of the chin anteriorly; but even in this event, which is the most favorable for a face-case, we find that one out of ten children perishes.

If we are successful in that variety of treatment employed in our cases, we convert a complicated labor, attended by many dangers, into one perfectly natural with respect to the presentation. If successful, we obviate the necessity of all the tedious and uncertain endeavors recommended to assist in rotation of the chin forward; and, in all probability, we do away with the use of the forceps, with version, and perhaps with craniotomy. It must be remembered, also, that we can never predetermine whether or not a chin, which enters the pelvis posteriorly, will rotate anteriorly during descent; and, if we leave the case to Nature, and then find that no rotation takes place, we have lost the opportunity favorable to the performance of the operation to rectify the presentation. The only dangers which could fairly be attributed to the method which we advocate are those arising from the introduction of a part of the hand into the uterus, and from causing pain, and possibly some shock, to a delicate nervous system by the presence of the hand in an undilated vagina. We preclude the possibility of the second danger by the employment of an anæsthetic, while, at the present day, the first is not believed to be a serious one. In fact, the patient is exposed to but little more risk from this source, than from a thorough examination of a presenting part through a slightly-dilated os. As a possible source of danger, I do not mention the establishment of a brow-presentation, because I do not think it exists. When a head, presenting by the face, *has descended* into the pelvis, the adoption of the method advised by Clark and Hodge—i. e., upward pressure on the malar bones—certainly appears to be attended by that source of danger. Our manipulation is performed when the head is above the brim of the pelvis and freely movable. The surrounding structures, which may scarcely be in apposition with the head, offer no resistance to the movement of flexion, which, when once commenced, can hardly fail of completion.

If we should fail in our efforts, we have not further complicated our case, the face still remaining as the presenting part.

From the difficulty experienced in the delivery of the head in the second case recorded, there is but little doubt that, had the child descended with the face presenting, we should have been compelled to perform craniotomy before the completion of delivery.

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